Maricopa County
Department of Public Health
Division of Clinical Services

PATIENT LABEL

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize the Maricopa County Department of Public Health to disclose the following information from the health record of:

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Please mark the records being requested:

☐ Laboratory Results ☐ HIV Lab Results ☐ Entire Record* ☐ Immunization Records ☐ Progress Notes
☐ Correspondence ☐ Social Worker Notes ☐ X-Ray Report ☐ X-Ray Films ☐ Payment Record
☐ Photos ☐ Referrals ☐ Other (Specify): _____

From Service Date: _____ to _____

***Note: HIV-related information is not subject to disclosure unless specifically authorized**

Purpose for Release: ☐ Personal Use ☐ Legal Purpose ☐ Continuation of Care ☐ Other: _____

Please select method of delivery:

☐ Fax to: _____ _____
Company/Person/Facility Fax #

☐ Mail to: _____
Company/Person/Facility

_____
Address City State Zip

☐ Pick-up: Please contact me at _____ when records are available for pick-up
Phone Number

- I understand that I may refuse to sign this authorization form. I understand that Maricopa County will not condition or deny treatment on my signing this authorization.
- I understand that I may submit a written request to revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Maricopa County's Notice of Privacy Practices explains the process for revocation.
- I understand that, if this information is disclosed to a third party, the information may no longer be protected by state or federal regulations and may be re-disclosed by the person or organization that receives the information.
- I release Maricopa County, its employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.
- I certify that this request has been made freely and voluntarily and that the information above is accurate and complete to the best of my knowledge.
- Unless I revoke this authorization earlier, **it will expire 6 months from the date signed** or as specified: _____.

_____ _____
Signature of Patient (or Parent/Guardian of Minor Child) Date

In requesting the medical records as the designated agent, in signing below, I attest to the continuing inability of the above patient to make or communicate health care decisions.

_____ _____
Signature of Legal Representative Date

_____ _____
Printed Name of Parent/Guardian/Legal Representative Relationship to Patient

Date Received: _____ Date Completed: _____

☐ **ID Verified** Processor: _____